

South Carolina Retirement Systems

Service and Disability Retirement Claims

Customer Training Module

Disclaimer

THIS PRESENTATION DOES NOT CREATE AN EXPRESS OR IMPLIED CONTRACT OF EMPLOYMENT WITH A MEMBER OF THE SOUTH CAROLINA RETIREMENT SYSTEMS.

This presentation is meant to serve as a guide but does not constitute a binding representation of the South Carolina Retirement Systems. The statutes governing the South Carolina Retirement Systems are found in Title 9 of the South Carolina Code of Laws, and should there be any conflict between this presentation and the statutes or Retirement Systems' policies, the statutes and policies will prevail.

Employers covered by the South Carolina Retirement Systems are not agents of the Retirement Systems.

Duplication of this presentation, either in part or in whole, is forbidden without the express written permission of the South Carolina Retirement Systems.

SCRS

When Can I Retire in SCRS?

- **If Your Current Membership Began After December 31, 2000
(5 years earned service required)**

Regular Service Retirement (Unreduced Annuity)

- 28 years of service credit on date of retirement [of which, at least 5 combined (SCRS/PORS/GARS) must be earned service]
- Age 65 on date of retirement with at least five years of combined (SCRS/PORS/GARS) earned service at retirement

Early Retirement (Reduced 5% for each year of age less than 65) 25 % maximum reduction)

- Age 60 on date of retirement with at least five years of combined (SCRS/PORS/GARS) earned service

Early Retirement (Reduced 4% for each year of service less than 28) (12% maximum reduction)

- At least age 55 on date of retirement and a minimum of 25 years of service credit [of which, at least 5 combined (SCRS/PORS/GARS) must be earned service. Not eligible for a COLA until second July 1 after turning age 60 or would have reached 28 years. Health coverage restrictions may also apply.

When Can I Retire in SCRS?

- **If Your Current Membership Began Before January 1, 2001:**
(Auxiliary Vesting)

Regular Service Retirement (Unreduced Annuity):

- 28 years of service credit on date of retirement [of which, at least 5 combined (SCRS/PORS/GARS) creditable years of service were accrued on December 31, 2000, and not subsequently withdrawn];
- Age 65 on date of retirement with at least five years of combined creditable service (SCRS/PORS/GARS) accrued on December 31, 2000, and not subsequently withdrawn;

Early Retirement (Reduced 5% for each year of age less than 65) (25 % maximum reduction)

- Age 60 on date of retirement with at least five years of combined creditable (SCRS/PORS/GARS) service were accrued on December 31, 2000 and not subsequently withdrawn;
- Both age 60 on December 31, 2000, and an active, contributing member on December 31, 2000;

Early Retirement (Reduced 4% for each year of service less than 28) (12% maximum reduction)

- At least age 55 on date of retirement and a minimum of 25 years of service credit [of which, at least 5 combined (SCRS/PORS/GARS) creditable years of service were accrued on December 31, 2000, and not subsequently withdrawn.] Not eligible for a COLA until second July 1 after turning age 60 or would have reached 28 years, Health coverage restrictions may also apply.

SCRS Retirement Formula

- **Class II (AFC x years of service x 0.0182) or Class I (AFC x years of service x 0.0145)**
 - Result represents annual unreduced benefit for maximum (Option A) payment plan
 - Divide by 12 for standard gross monthly benefit
 - Apply early retirement reduction factor and/or joint- survivor factor (Payment Plan Option B or C)

Teacher and Employee Retention Incentive (TERI) (9-1-2210)

- **TERI (a deferred retirement option plan)**
- **No interest accrued on accumulated benefits in TERI account**
- **Member is retired from the Retirement Systems**
- **TERI participant no longer earns service credit**
- **Monthly retirement annuity payments accumulate in a member's TERI account and are distributed when the member terminates employment**
- **For TERI retirement dates as of July 1, 2005, and after, the average final compensation (AFC) is recalculated at the end of the TERI period to include payment for unused annual leave made at termination**
- **Not eligible for disability retirement or service purchases**

SCRS TERI Retirement

- **Same rules apply as regular retirement for eligibility and timely filing of a retirement application with one exception:**
 - **Date of retirement for TERI must be the day the program begins (9-1-2210); therefore, TERI date may not be retroactive.**
- **Employers receive a monthly listing of retirement claims released to payroll. It is very important that employers review and advise if an employee who has entered TERI participation does not appear on the list, since SCRS cannot retroactively establish TERI.**

SCRS TERI Retirement

- **TERI participation cannot exceed five years (60 monthly deferred retirement benefits)**
- **If the first month of retirement is a partial month, it will count as one month of TERI participation**
- **If the member was previously retired and received a retirement benefit, the member may not participate in TERI (9-1-2210 (I))**

Form 6101S
SCRS Service
Retirement
Application

FOR DATES OF RETIREMENT OF JULY 1, 2005, OR AFTER					OFFICE USE ONLY	
Form 6101S Revised 05/13/2005 Page 1			SCRS SERVICE RETIREMENT APPLICATION State Budget and Control Board South Carolina Retirement Systems P.O. Box 11960, Columbia, SC 29211-1960			<input type="checkbox"/> SCRS <input type="checkbox"/> Correlated _____ <input type="checkbox"/> Disability pending <input type="checkbox"/> TERI Participant
The member must be off the payroll from all employment under South Carolina Retirement System, Police Officers Retirement System, or the State Optional Retirement Program as of the effective date of retirement. Applications for retirement may be filed as early as six months prior to, and up to three months after, your service retirement effective date.						
Section I (Attach Your Birth Certificate)		PERSONAL INFORMATION			TYPE OR PRINT IN BLUE INK	
LAST NAME & SUFFIX (Jr., Sr., etc.) DOE		FIRST/MIDDLE NAME JOHN		SOCIAL SECURITY NUMBER 000-00-0000		
Address 1 MAIN STREET				Date of Birth (proof required) 11-03-1961		Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F
City COLUMBIA		State SC	ZIP+4 29229	Home Phone 803-123-4567		Work Phone 803-456-1234
Section II SCRS RETIREMENT PLAN ELECTION AND BENEFICIARY DESIGNATION YOUR PAYMENT PLAN MAY NOT BE CHANGED ONCE BENEFITS ARE FIRST PAYABLE, except as noted on the reverse side. If designating more than three beneficiaries, complete and attach an additional Form 6101S. For all plans, attach a copy of your birth certificate and your current driver's license or special Identification card issued by your State Department of Transportation or Public Safety. For any joint retiree-survivor plan, attach your beneficiary's birth certificate.						
<input type="checkbox"/> Check here if payments are to be paid through a trust and attach a completed Form 1113, Certification of Trust.						
<input checked="" type="checkbox"/> OPTION A (Maximum-Retiree Only) <input type="checkbox"/> OPTION B (100% - 100% Joint Retiree-Survivor) <input type="checkbox"/> OPTION C (100% - 50% Joint Retiree-Survivor)						
1. Name of Beneficiary JANE DOE		Social Security #/Federal ID# 000-00-0001		Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	Date of Birth 11-28-1958	Relationship (Check one) <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Other
2. Name of Beneficiary		Social Security #		Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth	Relationship (Check one) <input type="checkbox"/> Spouse <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Other
3. Name of Beneficiary		Social Security #		Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth	Relationship (Check one) <input type="checkbox"/> Spouse <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Other
Section III RETIREE GROUP LIFE INSURANCE <input checked="" type="checkbox"/> CHECK IF SAME BENEFICIARY(IES) AS IN SECTION II						
1. Name of Beneficiary		Social Security #/Federal ID#		Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth	Relationship (Check one) <input type="checkbox"/> Spouse <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Other
2. Name of Beneficiary		Social Security #		Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth	Relationship (Check one) <input type="checkbox"/> Spouse <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Other
3. Name of Beneficiary		Social Security #		Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth	Relationship (Check one) <input type="checkbox"/> Spouse <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Other
Section IV EMPLOYMENT INFORMATION						
Current/Former Employer(s) ANY EMPLOYER				Your Position Title ASSISTANT		
Last day on payroll will be or was: 06-30-2006		Effective Date of Retirement <input checked="" type="checkbox"/> Day following last day on payroll <input type="checkbox"/> Specific date:				
Do you plan to defer your retirement benefits through the Teacher and Employee Retention Incentive (TERI) program? If yes, please attach a completed Form 6201 from your employer indicating the dates of your TERI period. <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No						
Section V SIGNATURE STATEMENT						
Please read the Authorization section of the Instructions on the reverse (page 2) before signing this form IN BLUE INK. I hereby certify I have read and understand the information on the reverse side (page 2), including the authorization, and I agree to the terms stated.						
MEMBER'S SIGNATURE _____ DATE _____ (Certified copy of legal authorization required with signature other than applicant's)						
WITNESS _____ DATE _____ (Required only when signed by mark)						
THE LANGUAGE USED IN THIS DOCUMENT DOES NOT CREATE ANY CONTRACTUAL RIGHTS OR ENTITLEMENTS AND DOES NOT CREATE A CONTRACT BETWEEN THE MEMBER AND THE SOUTH CAROLINA RETIREMENT SYSTEMS. THE SOUTH CAROLINA RETIREMENT SYSTEMS RESERVES THE RIGHT TO REVISE THE CONTENT OF THIS DOCUMENT.						
Please call SC Retirement Systems Customer Service with any questions: 1-800-868-9002 (In state) or (803) 737-6800						

Form 6302

***Retiring Member's
Service Application
Checklist***

RETIRING MEMBER'S SERVICE APPLICATION CHECKLIST
State Budget and Control Board
South Carolina Retirement Systems
Box 11960, Columbia, SC 29211-1960

To avoid delays in receiving benefits, please check the following items carefully before submitting your application:

- ☐ Application is submitted no earlier than 6 months prior to your planned retirement date.
- ☐ Signatures are completed in blue ink on your application.
- ☐ No corrections or white-outs are made on the application.
- ☐ Only one method of payment is selected in Section II.
- ☐ Last day on payroll is indicated in Section IV. This should match the date indicated by your employer on the Employer Certification of Last Day Paid (Form 6201).
- ☐ Application is signed.
- ☐ A copy of your current driver's license or special identification card issued by your State Department of Transportation or Public Safety is attached.
- ☐ A copy of your birth certificate (or other proof of birth if a public birth certificate does not exist) is attached.
- ☐ If you selected a joint retiree-survivor payment plan, a copy of a birth certificate for each beneficiary is attached.
- ☐ Employer Certification of Last Day Paid (Form 6201), completed by your employer, is attached.
- ☐ Service and Installment purchases should be paid in full prior to anticipated retirement date.
- ☐ Pension Withholding Certificate/Automatic Deposit Authorization (Form 7202) is completed and returned to the Benefits Department, South Carolina Retirement Systems, using the separate envelope provided. For automatic deposit of benefit payments, please complete the automatic deposit authorization section of the Form 7202 and tape a voided check to the form.
- ☐ Employer Certification of Last Day Paid (Form 6201). This is to be completed by your employer. If you are going to participate in the TERI (Teacher and Employee Retention Incentive) program, you are required to sign Form 6201 as well. For purposes of TERI participation, your termination date from your employer should certify that you were an active contributing member upon TERI participation and should be no more than one day prior to your TERI participation (effective date of retirement) begin date.

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PORS

When Can I Retire in PORs?

- **If Your Current Membership Began After December 31, 2000
(5 years earned service required)**

Regular Service Retirement (Unreduced Annuity)

- 25 years of service credit on date of retirement [of which, at least 5 combined (SCRS/PORS/GARS) must be earned service at retirement]

Early Service Retirement (Unreduced Annuity):

- Age 55 on date of retirement [of which, at least five years of combined (SCRS/PORS/GARS) earned service at retirement]

- **If Your Current Membership Began Before January 1, 2001:
(Auxiliary Vesting)**

Regular Service Retirement (Unreduced Annuity):

- 25 years of service credit on date of retirement [of which, at least 5 combined (SCRS/PORS/GARS) creditable years of service were accrued on December 31, 2000, and not subsequently withdrawn];

Early Service Retirement (Unreduced Annuity):

- Age 55 on date of retirement with at least 5 combined (SCRS/PORS/GARS) creditable service were accrued on December 31, 2000, and not subsequently withdrawn;

PORS Retirement Formula

- **Class I Service Formula: \$10.97 monthly for each year of service equals monthly gross retirement benefit (less any Option B or C payment plan joint-survivor option factor)**
- **Class II Service Formula: $AFC \times \text{years of service} \times 0.0214$**
 - **Result represents annual unreduced benefit for maximum (Option A) payment plan**
 - **Divide by 12 for standard monthly benefit**
 - **Apply early retirement reduction factor and/or joint-survivor factor (Payment Plan Option B or C)**

Form 6101P
PORS Service
Retirement Application

FOR DATES OF RETIREMENT OF JULY 1, 2005, OR AFTER PORS SERVICE RETIREMENT APPLICATION				OFFICE USE ONLY <input type="checkbox"/> PORS <input type="checkbox"/> Correlated _____ <input type="checkbox"/> Disability Pending _____	
<div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"> Form 6101P Revised 06/13/2005 Page 1 </div> <div style="width: 40%; text-align: center;"> State Budget and Control Board South Carolina Retirement Systems P.O. Box 11960, Columbia, SC 29211-1960 </div> <div style="width: 30%;"></div> </div> <p style="font-size: small; text-align: center;">The member must be off the payroll from all employment under South Carolina Retirement System, Police Officers Retirement System, or the State Optional Retirement Program as of the effective date of retirement. Applications for retirement may be filed as early as six months prior to, and up to three months after, your service retirement effective date.</p>					
Section I (Attach Your Birth Certificate)		PERSONAL INFORMATION		TYPE OR PRINT IN BLUE INK	
LAST NAME & SUFFIX DOE		FIRST/MIDDLE NAME JANE		SOCIAL SECURITY NUMBER 000-00-0000	
Address 1 MAIN STREET				Date of Birth (proof required) 11-28-1958	
City COLUMBIA		State SC		ZIP+4 29229	
		Home Phone 803-123-4567		Work Phone 803-456-7890	
Section II PORS RETIREMENT PLAN ELECTION AND BENEFICIARY DESIGNATION					
<p style="font-size: x-small;">YOUR PAYMENT PLAN MAY NOT BE CHANGED ONCE BENEFITS ARE FIRST PAYABLE, except as noted on the reverse side. If designating more than three beneficiaries, complete and attach an additional Form 6101P. For all plans, attach a copy of your birth certificate and your current driver's license or special identification card issued by your State Department of Transportation or Public Safety. For any joint retiree-survivor plan, attach your beneficiary's birth certificate.</p> <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <input type="checkbox"/> Check here if payments are to be paid through a trust and attach a completed Form 1113, Certification of Trust. </div> <div style="width: 50%;"> <input type="checkbox"/> OPTION A (Maximum-Retiree Only) <input type="checkbox"/> OPTION B (100% - 100% Joint Retiree-Survivor) <input checked="" type="checkbox"/> OPTION C (100% - 50% Joint Retiree-Survivor) </div> </div>					
1. Name of Beneficiary JOHN DOE		Social Security #/Federal ID# 000-00-0001		Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F Date of Birth 11-03-1961 Relationship (Check one) <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Other	
2. Name of Beneficiary JOE DOE		Social Security # 000-00-0002		Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F Date of Birth 03-03-1987 Relationship (Check one) <input type="checkbox"/> Spouse <input checked="" type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Other	
3. Name of Beneficiary		Social Security #		Sex <input type="checkbox"/> M <input type="checkbox"/> F Date of Birth Relationship (Check one) <input type="checkbox"/> Spouse <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Other	
Section III <input type="checkbox"/> RETIREE GROUP LIFE INSURANCE <input type="checkbox"/> CHECK IF SAME BENEFICIARY(IES) AS IN SECTION II					
1. Name of Beneficiary JOHN DOE		Social Security #/Federal ID# 000-00-0001		Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F Date of Birth 11-03-1961 Relationship (Check one) <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Other	
2. Name of Beneficiary		Social Security #		Sex <input type="checkbox"/> M <input type="checkbox"/> F Date of Birth Relationship (Check one) <input type="checkbox"/> Spouse <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Other	
3. Name of Beneficiary		Social Security #		Sex <input type="checkbox"/> M <input type="checkbox"/> F Date of Birth Relationship (Check one) <input type="checkbox"/> Spouse <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Other	
Section IV EMPLOYMENT INFORMATION					
Current/Former Employer(s) ANY EMPLOYER				Your Position Title DEPUTY	
Last day on payroll will be or was: 06-30-2006		Effective Date of Retirement <input checked="" type="checkbox"/> Day following last day on payroll <input type="checkbox"/> Specific date: _____			
Section V SIGNATURE STATEMENT					
<p style="font-size: x-small;">Please read the Authorization section of the instructions on the reverse (page 2) before signing this form IN BLUE INK.</p> <p style="font-size: x-small;">I hereby certify I have read and understand the information on the reverse side (page 2), including the authorization, and I agree to the terms stated.</p>					
MEMBER'S SIGNATURE _____				DATE _____	
(Certified copy of legal authorization required with signature other than applicant's)					
WITNESS _____				DATE _____	
(Required only when signed by mark)					
<p style="font-size: x-small;">THE LANGUAGE USED IN THIS DOCUMENT DOES NOT CREATE ANY CONTRACTUAL RIGHTS OR ENTITLEMENTS AND DOES NOT CREATE A CONTRACT BETWEEN THE MEMBER AND THE SOUTH CAROLINA RETIREMENT SYSTEMS. THE SOUTH CAROLINA RETIREMENT SYSTEMS RESERVES THE RIGHT TO REVISE THE CONTENT OF THIS DOCUMENT.</p> <p style="font-size: x-small;">Please call SC Retirement Systems Customer Service with any questions: 1-800-868-9002 (In state) or (803) 737-6800</p>					

Form 6302
Retiring Member's
Service Application
Checklist

RETIRING MEMBER'S SERVICE APPLICATION CHECKLIST
State Budget and Control Board
South Carolina Retirement Systems
Box 11960, Columbia, SC 29211-1960

To avoid delays in receiving benefits, please check the following items carefully before submitting your application:

- ☐ Application is submitted no earlier than 6 months prior to your planned retirement date.
- ☐ Signatures are completed in blue ink on your application.
- ☐ No corrections or white-outs are made on the application.
- ☐ Only one method of payment is selected in Section II.
- ☐ Last day on payroll is indicated in Section IV. This should match the date indicated by your employer on the Employer Certification of Last Day Paid (Form 6201).
- ☐ Application is signed.
- ☐ A copy of your current driver's license or special identification card issued by your State Department of Transportation or Public Safety is attached.
- ☐ A copy of your birth certificate (or other proof of birth if a public birth certificate does not exist) is attached.
- ☐ If you selected a joint retiree-survivor payment plan, a copy of a birth certificate for each beneficiary is attached.
- ☐ Employer Certification of Last Day Paid (Form 6201), completed by your employer, is attached.
- ☐ Service and Installment purchases should be paid in full prior to anticipated retirement date.
- ☐ Pension Withholding Certificate/Automatic Deposit Authorization (Form 7202) is completed and returned to the Benefits Department, South Carolina Retirement Systems, using the separate envelope provided. For automatic deposit of benefit payments, please complete the automatic deposit authorization section of the Form 7202 and tape a voided check to the form.
- ☐ Employer Certification of Last Day Paid (Form 6201). This is to be completed by your employer. If you are going to participate in the TERI (Teacher and Employee Retention Incentive) program, you are required to sign Form 6201 as well. For purposes of TERI participation, your termination date from your employer should certify that you were an active contributing member upon TERI participation and should be no more than one day prior to your TERI participation (effective date of retirement) begin date.

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Disability Retirement Applications

SCRS & PORS Disability Retirement (9-1-1540; 9-1-1560; and 9-11-80)

- Must have 5 years of earned service credit to be eligible (waived if disability is a result of job-related injury)**
- Must be in the service of an employer covered by SCRS to be eligible to apply for disability retirement and application received by SCRS**
- SCRS - must be under age 65; PORS – must be under the age of 55**
- Generally, will be in a reduced-work capacity (on annual/sick leave, leave without pay, diminished capacity, or reduced hours)**
- Must be mentally or physically incapacitated from performing employee's job duties and that this incapacitation is likely to be permanent**
- Earliest retirement date is 30 days from date application is received or day after termination, whichever is later**

Form 6151S
SCRS Disability
Retirement
Application

FOR DATES OF RETIREMENT OF JULY 1, 2005, OR AFTER						OFFICE USE ONLY	
Form 6151S Revised 06/14/2005 Page 1 SCRS DISABILITY RETIREMENT APPLICATION State Budget and Control Board South Carolina Retirement Systems P.O. Box 11960, Columbia, SC 29211-1960						<input checked="" type="checkbox"/> SCRS <input type="checkbox"/> Correlated _____ <input type="checkbox"/> Date first eligible for disability retirement _____ <input type="checkbox"/> Service application on file _____	
Applications for disability retirement must be filed while you are on your employer's payroll in a paid or approved unpaid capacity. If you are unable to complete this application, a designee (employer, legal counsel, power of attorney) may complete the application on your behalf, but may not complete method of payment or beneficiary information. Please see the reverse side for information about retirement effective dates.							
Section I (Attach Your Birth Certificate)		PERSONAL INFORMATION				TYPE OR PRINT IN BLUE INK	
LAST NAME & SUFFIX (Jr., Sr., etc.) DOE		FIRST/MIDDLE NAME JOHN		SOCIAL SECURITY NUMBER 000-00-0000			
Address 1 MAIN STREET				Date of Birth (proof required) 11-29-1959		Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	
City COLUMBIA		State SC		ZIP+4 29229		Home Phone 803-123-4567	
						Work Phone 803-456-1234	
Section II SCRS RETIREMENT PLAN ELECTION AND BENEFICIARY DESIGNATION							
YOUR PAYMENT PLAN MAY NOT BE CHANGED ONCE BENEFITS HAVE BEGUN AFTER RETIREMENT, except as noted on the reverse side. If designating more than three beneficiaries, complete and attach an additional Form 6151S. For all plans, attach a copy of your birth certificate and your current driver's license or special identification card issued by your State Department of Transportation or Public Safety. For any joint retiree-survivor plan, attach your beneficiary's birth certificate.							
<div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> Check here if payments are to be paid through a trust and attach a completed Form 1113, Certification of Trust. </div> <div> <input type="checkbox"/> OPTION A (Maximum-Retiree Only) <input type="checkbox"/> OPTION B (100% - 100% Joint Retiree-Survivor) <input checked="" type="checkbox"/> OPTION C (100% - 50% Joint Retiree-Survivor) </div> </div>							
1. Name of Beneficiary JANE DOE		Social Security #/Federal ID# 000-00-0001		Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		Date of Birth 11-03-1961	
						Relationship (Check one) <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Other	
2. Name of Beneficiary		Social Security #		Sex <input type="checkbox"/> M <input type="checkbox"/> F		Date of Birth	
						Relationship (Check one) <input type="checkbox"/> Spouse <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Other	
3. Name of Beneficiary		Social Security #		Sex <input type="checkbox"/> M <input type="checkbox"/> F		Date of Birth	
						Relationship (Check one) <input type="checkbox"/> Spouse <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Other	
Section III							
<input type="checkbox"/> RETIREE GROUP LIFE INSURANCE <input type="checkbox"/> CHECK IF SAME BENEFICIARY(IES) AS IN SECTION II							
1. Name of Beneficiary JOE DOE		Social Security #/Federal ID# 000-00-0002		Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		Date of Birth 03-03-1987	
						Relationship (Check one) <input type="checkbox"/> Spouse <input checked="" type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Other	
2. Name of Beneficiary		Social Security #		Sex <input type="checkbox"/> M <input type="checkbox"/> F		Date of Birth	
						Relationship (Check one) <input type="checkbox"/> Spouse <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Other	
3. Name of Beneficiary		Social Security #		Sex <input type="checkbox"/> M <input type="checkbox"/> F		Date of Birth	
						Relationship (Check one) <input type="checkbox"/> Spouse <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Other	
Section IV EMPLOYMENT INFORMATION							
Current/Former Employer(s)				Your Position Title			
<div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> Currently on employer's payroll in a paid capacity. Check One <input checked="" type="checkbox"/> Currently on employer's payroll in an unpaid capacity. My unpaid leave of absence began: 7/1/06 <input type="checkbox"/> Last day on payroll was: _____ </div> <div> <input type="checkbox"/> If disability is the result of a job-related injury, check this box and attach employer's first report of injury form. <input type="checkbox"/> If receiving Workers' Compensation benefits check here. </div> </div>							
Section V SIGNATURE STATEMENT							
Please read the Authorization section of the instructions on the reverse (page 2) before signing this form in BLUE INK. I hereby certify I have read and understand the information on the reverse side (page 2), including the authorization, and I agree to the terms stated.							
MEMBER'S SIGNATURE _____						DATE _____	
(Certified copy of legal authorization required with signature other than applicant's)							
WITNESS _____						DATE _____	
(Required only when signed by mark)							
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Please call SC Retirement Systems Customer Service with any questions: 1-800-868-9002 (In state) or (803) 737-6800							

Form 6151P
PORS Disability
Retirement
Application

FOR DATES OF RETIREMENT OF JULY 1, 2005, OR AFTER					OFFICE USE ONLY	
Form 6151P Revised 06/14/2005 Page 1			PORS DISABILITY RETIREMENT APPLICATION State Budget and Control Board South Carolina Retirement Systems P.O. Box 11960, Columbia, SC 29211-1960			<input type="checkbox"/> PORS <input type="checkbox"/> Correlated <input type="checkbox"/> Date first eligible for disability retirement <input type="checkbox"/> Service application on file
Applications for disability retirement must be filed while you are on your employer's payroll in a paid or approved unpaid capacity. If you are unable to complete this application, a designee (employer, legal counsel, power of attorney) may complete the application on your behalf, but may not complete method of payment or beneficiary information. Please see the reverse side for information about retirement effective dates.						
Section I (Attach Your Birth Certificate)		PERSONAL INFORMATION			TYPE OR PRINT IN BLUE INK	
LAST NAME & SUFFIX (Jr., Sr., etc.) DOE		FIRST/MIDDLE NAME JANE		SOCIAL SECURITY NUMBER 000-00-0000		
Address 1 MAIN STREET				Date of Birth (proof required) 11-28-1958		Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F
City COLUMBIA		State SC		ZIP+4 29229		Home Phone 803-012-3456
						Work Phone 803-123-4567
Section II PORS RETIREMENT PLAN ELECTION AND BENEFICIARY DESIGNATION						
YOUR PAYMENT PLAN MAY NOT BE CHANGED ONCE BENEFITS HAVE BEGUN AFTER RETIREMENT, except as noted on the reverse side. If designating more than three beneficiaries, complete and attach an additional Form 6151P. For all plans, attach a copy of your birth certificate and your current driver's license or special identification card issued by your State Department of Transportation or Public Safety. For any joint retiree-survivor plan, attach your beneficiary's birth certificate.						
<input type="checkbox"/> Check here if payments are to be paid through a trust and attach a completed Form 1113, Certification of Trust.						
<input type="checkbox"/> OPTION A (Maximum-Retiree Only) <input checked="" type="checkbox"/> OPTION B (100% - 100% Joint Retiree-Survivor) <input type="checkbox"/> OPTION C (100% - 50% Joint Retiree-Survivor)						
1. Name of Beneficiary JOHN DOE		Social Security #/Federal ID# 000-00-0001		Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	Date of Birth 11-03-1961	Relationship (Check one) <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Other
2. Name of Beneficiary JIMMY DOE		Social Security # 000-00-0002		Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	Date of Birth 03-03-1987	Relationship (Check one) <input type="checkbox"/> Spouse <input checked="" type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Other
3. Name of Beneficiary		Social Security #		Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth	Relationship (Check one) <input type="checkbox"/> Spouse <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Other
Section III <input type="checkbox"/> RETIREE GROUP LIFE INSURANCE <input type="checkbox"/> CHECK IF SAME BENEFICIARY(IES) AS IN SECTION II						
1. Name of Beneficiary JOHN DOE		Social Security #/Federal ID# 000-00-0001		Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	Date of Birth 11-03-1961	Relationship (Check one) <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Other
2. Name of Beneficiary		Social Security #		Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth	Relationship (Check one) <input type="checkbox"/> Spouse <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Other
3. Name of Beneficiary		Social Security #		Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth	Relationship (Check one) <input type="checkbox"/> Spouse <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Other
Section IV EMPLOYMENT INFORMATION						
Current/Former Employer(s) ANY EMPLOYER				Your Position Title DEPUTY		
<input checked="" type="checkbox"/> Currently on employer's payroll in a paid capacity. <input type="checkbox"/> Currently on employer's payroll in an unpaid capacity. My unpaid leave of absence began: _____ <input type="checkbox"/> Last day on payroll was: _____				<input checked="" type="checkbox"/> If disability is the result of a job-related injury, check this box and attach employer's first report of injury form. <input type="checkbox"/> If receiving Workers' Compensation benefits check here.		
Section V SIGNATURE STATEMENT						
Please read the Authorization section of the Instructions on the reverse (page 2) before signing this form IN BLUE INK. I hereby certify I have read and understand the information on the reverse side (page 2), including the authorization, and I agree to the terms stated.						
MEMBER'S SIGNATURE _____						DATE _____
(Certified copy of legal authorization required with signature other than applicant's)						
WITNESS _____						DATE _____
(Required only when signed by mark)						
THE LANGUAGE USED IN THIS DOCUMENT DOES NOT CREATE ANY CONTRACTUAL RIGHTS OR ENTITLEMENTS AND DOES NOT CREATE A CONTRACT BETWEEN THE MEMBER AND THE SOUTH CAROLINA RETIREMENT SYSTEMS. THE SOUTH CAROLINA RETIREMENT SYSTEMS RESERVES THE RIGHT TO REVISE THE CONTENT OF THIS DOCUMENT.						
Please call SC Retirement Systems Customer Service with any questions: 1-800-868-9002 (In state) or (803) 737-6800						

Form 6352

Retiring Member's

Disability

Application

Checklist

RETIRING MEMBER'S DISABILITY APPLICATION CHECKLIST
State Budget and Control Board
South Carolina Retirement Systems
Box 11960, Columbia, SC 29211-1960

To avoid delays in receiving benefits, please check the following items carefully before submitting your application:

- ☐ Application is submitted while you are a member in service with a participating employer.
- ☐ Signatures are completed in blue ink on your application.
- ☐ No corrections or white-outs are made on the application.
- ☐ Only one method of payment is selected in Section II.
- ☐ Beneficiary is designated in Section II.
- ☐ Payroll status is indicated in Section IV.
- ☐ Application is signed.
- ☐ A copy of your current driver's license or special identification card issued by your State Department of Transportation or Public Safety is attached.
- ☐ A copy of your birth certificate (or other proof of birth if a public birth certificate does not exist) is attached.
- ☐ If you selected a joint retiree-survivor payment plan, a copy of a birth certificate (or other acceptable proof of birth if a public birth certificate does not exist) for each beneficiary is attached.
- ☐ Disability Report (Form 6251) is completed in full, signed, dated, and attached.
- ☐ Five Authorizations for Release of Information to Disability Determination Service (Form 6255) are signed and attached. **These forms must be dated.** Do not have medical records forwarded directly to South Carolina Retirement Systems by your treating physician or other health care provider.
- ☐ Job Description (Form 6254) and Disability Employment Status Report (Form 6253) have been given to your employer to complete.
- ☐ Service and Installment purchases should be paid in full prior to anticipated retirement date.
- ☐ Pension Withholding Certificate/Automatic Deposit Authorization (Form 7202) is completed and returned to the Benefits Department, South Carolina Retirement Systems, using the separate envelope provided. For automatic deposit of benefit payments, please complete the automatic deposit authorization section of the Form 7202 and tape a voided check to the form.

NOTE: If you are approved for disability retirement benefits, South Carolina Retirement Systems will forward a Form 6201 (Employer Certification of Last Day Paid) to your employer for completion. Your employer will complete the Form 6201 to certify the last day you earned compensation or expect to earn compensation.

THE LANGUAGE USED IN THIS DOCUMENT DOES NOT CREATE ANY CONTRACTUAL RIGHTS OR ENTITLEMENTS AND DOES NOT CREATE A CONTRACT BETWEEN THE MEMBER AND THE SOUTH CAROLINA RETIREMENT SYSTEMS. THE SOUTH CAROLINA RETIREMENT SYSTEMS RESERVES THE RIGHT TO REVISE THE CONTENT OF THIS DOCUMENT

Please call SC Retirement Systems Customer Service with any questions: (800) 868-9002 (in state) or (803) 737-6800

Employer Forms

Form 6201
Employer
Certification of
Last Day Paid

Form 6201 Revised 06/13/2006 Page 1 of 2	EMPLOYER CERTIFICATION OF LAST DAY PAID State Budget and Control Board - South Carolina Retirement Systems Customer Annuity Claims PO Box 11960, Columbia SC 29211-1960
Please attach to retirement application or fax to - Customer Annuity Claims' Unit at 803-737-7752. The purpose of this information is to determine an effective date of retirement for estimated payroll purposes.	
Retiring Member's Name: <u>JOHN DOE</u> SSN: <u>000-00-0000</u> Planned Retirement Date: <u>07-01-2006</u> <input checked="" type="checkbox"/> SCRS <input type="checkbox"/> PORS <input type="checkbox"/> GARS <input type="checkbox"/> JSRS	
Section I SERVICE OR DISABILITY RETIREMENT INFORMATION	
Please indicate the last day the employee, as an active contributing member, earned compensation or is expected to earn compensation from your agency (last day of paid employment from which employee retirement contributions were or will be deducted): <u>06-30-2006</u>	
Even if the employee's actual termination date from your payroll will be the same as the date given above or will be after the date given above (due to workers' compensation, disability leave of absence without pay, Teacher and Employee Retention Incentive (TERI) program participation, etc.), please indicate the employee's actual date of termination from employment (For Teri participants, report the last day employed as an active member): <u>06-30-2006</u>	
Employer Name: <u>ANY EMPLOYER</u> Employer Code: <u>000.00</u> Completed by: <u>AUTHORIZED REPRESENTATIVE</u> Job Title: <u>BENEFITS ADMINISTRATOR</u> Phone Number: <u>803-123-4567</u> Fax Number: <u>803-456-1234</u> Authorized Employer Signature: <u>AUTHORIZED REP</u> Date: <u>7/15/2006</u>	
Section II FOR TEACHER AND EMPLOYEE RETENTION INCENTIVE PROGRAM PARTICIPANTS ONLY	
This is to certify that in conjunction with the above-named member's SCRS service retirement, the member and employer acknowledge the member's participation in the Teacher and Employee Retention Incentive (TERI) program on the TERI start date below and the termination of his or her participation on the TERI end date below:	
TERI Start Date: _____ TERI End Date: _____ Number of Months: _____ <small>(DATE OF RETIREMENT)</small> <small>(MAXIMUM OF 60 MONTHS)</small>	
_____ TERI Participant's (Employee's) Signature TERI Employer's Authorized Signature Date: _____ Date: _____	
<p>* For TERI participation, this termination date should be no more than one day prior to TERI start date (effective date of retirement) so as to certify that the member was actively employed upon TERI participation. For all retirees, complete Section I. For TERI retirees, complete Sections I and II.</p> <p>Please complete this form and attach it to the member's application for retirement.</p> <p>Please submit a corrected copy as soon as possible should any information change. The TERI participant or employer should notify the Retirement Systems' Payroll Department, either by telephone or in writing, three months prior to the TERI participant's TERI ending date.</p> <p>THE LANGUAGE USED IN THIS DOCUMENT DOES NOT CREATE ANY CONTRACTUAL RIGHTS OR ENTITLEMENTS AND DOES NOT CREATE A CONTRACT BETWEEN THE MEMBER AND THE SOUTH CAROLINA RETIREMENT SYSTEMS. THE SOUTH CAROLINA RETIREMENT SYSTEMS RESERVES THE RIGHT TO REVISE THE CONTENT OF THIS DOCUMENT.</p> <p>Please call SC Retirement Systems Customer Service with any questions: 1-800-868-9002 (in state) or 803-737-6800</p>	

Form 6253
Employer's
Disability
Employment Status
Report

Form 8253 Revised 02/03/2004 Print or type in black ink	EMPLOYER'S DISABILITY EMPLOYMENT STATUS REPORT To Be Completed by Applicant's Payroll/Benefits Officer State Budget and Control Board South Carolina Retirement Systems Attention: Customer Services Annuity Claims PO Box 11960, Columbia, SC 29211-1960	<input checked="" type="checkbox"/> SCRS <input type="checkbox"/> PORS <input type="checkbox"/> GARS
The individual indicated below has applied for disability retirement benefits. Please complete the information on the remainder of this form, and return it to the address listed above as soon as possible. Upon receipt of this completed form, the employee's application will be processed.		
Employee Name: <u>JOHN DOE</u>		Social Security Number: <u>000-00-0000</u>
Employer: <u>ANY EMPLOYER</u>		Employer Code: <u>000.00</u>
Position Title: <u>TEACHER</u>		
1. Is the position title shown above correct? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No (please explain) _____		2. Annual salary on date of disability: <u>\$ 40,000.00</u>
3a. Is the employee currently working? <input checked="" type="checkbox"/> No (last day physically worked): <u>05-11-2006</u> (skip to Question 4a) <input type="checkbox"/> Yes (proceed to Question 3b) <u>MM-DD-YYYY</u>		3b. Is the employee performing all regular duties? <input type="checkbox"/> Yes (skip to Question 6a) <input type="checkbox"/> No (proceed to Question 3c)
3c. In what capacity is the employee currently working? <input type="checkbox"/> Leave without pay (not terminated) (attach copy of Personnel Policy) <input type="checkbox"/> Light duty* <input type="checkbox"/> Diminished capacity* <input type="checkbox"/> Reduced hours <input type="checkbox"/> Other (please explain): _____		3d. Date member was placed in status shown at left: <u>MM-DD-YYYY</u>
*Attach letter explaining current duties in relation to normal work functions.		4a. Is this employee terminated? <input checked="" type="checkbox"/> No (skip to Question 5) <input type="checkbox"/> Yes (date of termination): <u>MM-DD-YYYY</u> (proceed to Question 4b)
4b. Last day compensation was earned (including pay continuation, using annual and sick leave): <u>MM-DD-YYYY</u>	4c. Amount of lump-sum payments for unused leave Annual leave \$ _____ Sick leave \$ _____	4d. Number of days of unused leave: (complete and proceed to Question 6a) Annual leave _____ Sick leave _____
5. Employee's current payroll status (check one and indicate appropriate date): <input type="checkbox"/> On annual leave (date leave began): _____ <input type="checkbox"/> On sick leave (date leave began): _____ <input type="checkbox"/> Other (please explain): _____ <input checked="" type="checkbox"/> On leave without pay (date leave began): <u>06-01-2006</u> <input type="checkbox"/> Applied for leave under sick leave bank (date leave begins): _____		
6a. Was this employee injured on the job? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes (date of injury): <u>MM-DD-YYYY</u>	6b. Is employee on leave without pay (not terminated) pending settlement of a Workers' Compensation claim? <input checked="" type="checkbox"/> No <input type="checkbox"/> Claim settled (date): <u>MM-DD-YYYY</u> <input type="checkbox"/> Yes	
I hereby certify that to the best of my knowledge, the information above correctly reflects the records of the employing entity.		
Prepared by: <u>AUTHORIZED REPRESENTATIVE</u>		Title: <u>BENEFITS COORDINATOR</u>
Signature: _____		Date: <u>6/15/2006</u> Telephone: <u>803-123-4567</u>
Return completed form to the SC Retirement Systems (address above). Please call SC Retirement Systems Customer Service with any questions: 1-800-868-9002 (in state) or 803-737-6800		

Form 6254
Employer's
Description
of Disability
Applicant's Job

Form 6254 Revised 02/03/2004 Print or type in black ink		EMPLOYER'S DESCRIPTION OF DISABILITY APPLICANT'S JOB (TO BE COMPLETED BY APPLICANT'S SUPERVISOR) State Budget and Control Board South Carolina Retirement Systems ATTENTION: CUSTOMER SERVICES ANNUITY CLAIMS PO Box 11960, Columbia SC 29211-1960			Retirement System <input checked="" type="checkbox"/> SCRS <input type="checkbox"/> PORS <input type="checkbox"/> GARS																															
The individual indicated below has applied for disability retirement benefits. Please complete the information on the remainder of this form, and return it to the address listed above as soon as possible. Upon receipt of this completed form, the employee's application will be processed.																																				
DISABILITY APPLICANT/EMPLOYEE INFORMATION																																				
1. Last Name & Suffix DOE		2. First/Middle Name JOHN		3. Social Security Number 000-00-0000																																
4. Position Title TEACHER		5. Employer ANY EMPLOYER		6. Employer Code 000.00																																
Date employee started this position: <u>05-01-1983</u> MM-DD-YYYY																																				
Date employee stopped work in this position because of disability: <u>05-12-2006</u>																																				
IN THIS JOB DID THE EMPLOYEE: <table style="width: 100%; margin-top: 5px;"> <tr> <td style="width: 60%;">1. Use machines, tools, or equipment of any kind?</td> <td style="width: 10%;"><input checked="" type="checkbox"/> Yes</td> <td style="width: 10%;"><input type="checkbox"/> No</td> </tr> <tr> <td>2. Use technical knowledge of any kind?</td> <td><input checked="" type="checkbox"/> Yes</td> <td><input type="checkbox"/> No</td> </tr> <tr> <td>3. Do any writing, complete reports, or perform similar duties?</td> <td><input checked="" type="checkbox"/> Yes</td> <td><input type="checkbox"/> No</td> </tr> <tr> <td>4. Have supervisory responsibilities?</td> <td><input checked="" type="checkbox"/> Yes</td> <td><input type="checkbox"/> No</td> </tr> </table>					1. Use machines, tools, or equipment of any kind?	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	2. Use technical knowledge of any kind?	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	3. Do any writing, complete reports, or perform similar duties?	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	4. Have supervisory responsibilities?	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No																				
1. Use machines, tools, or equipment of any kind?	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No																																		
2. Use technical knowledge of any kind?	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No																																		
3. Do any writing, complete reports, or perform similar duties?	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No																																		
4. Have supervisory responsibilities?	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No																																		
DESCRIBE BASIC DUTIES OF JOB BELOW AND ATTACH EMPLOYEE'S POSITION DESCRIPTION. ALSO, EXPLAIN ALL "YES" ANSWERS ABOVE BY GIVING A FULL DESCRIPTION OF: A. Type of machines, tools, or equipment used, and exact operations performed. B. The technical knowledge or skills involved. C. Type of writing done and nature of reports. D. The number of people supervised and the extent of supervision. <u>OPERATE COMPUTERS AND PROJECTORS.</u> <u>KNOWLEDGE/ABILITY TO WRITE LESSON PLANS, INSTRUCT STUDENTS, AND PERFORM RESEARCH.</u> <u>LESSON PLANS, PROGRESS/GRADE REPORTS, GRANTS, AND TEACHER/PARENT CORRESPONDENCE.</u> <u>20-30 STUDENTS PER CLASS AND CONTROL OF ENVIRONMENT W/ FOCUS ON LEARNING/SAFETY.</u>																																				
DESCRIBE THE KIND AND AMOUNT OF PHYSICAL ACTIVITY THIS JOB INVOLVED DURING A TYPICAL DAY IN TERMS OF:																																				
A. CHECK NUMBER OF HOURS A DAY: <table style="width: 100%; margin-top: 5px;"> <tr> <td style="width: 30%;">WALKING</td> <td style="width: 5%;">1</td><td style="width: 5%;">2</td><td style="width: 5%;"><input checked="" type="checkbox"/></td><td style="width: 5%;">3</td><td style="width: 5%;">4</td><td style="width: 5%;">5</td><td style="width: 5%;">6</td><td style="width: 5%;">7</td><td style="width: 5%;">8</td> </tr> <tr> <td>STANDING</td> <td>1</td><td>2</td><td><input type="checkbox"/></td><td>3</td><td>4</td><td><input checked="" type="checkbox"/></td><td>5</td><td>6</td><td>7</td><td>8</td> </tr> <tr> <td>SITTING</td> <td>1</td><td>2</td><td><input type="checkbox"/></td><td>3</td><td><input checked="" type="checkbox"/></td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td> </tr> </table>					WALKING	1	2	<input checked="" type="checkbox"/>	3	4	5	6	7	8	STANDING	1	2	<input type="checkbox"/>	3	4	<input checked="" type="checkbox"/>	5	6	7	8	SITTING	1	2	<input type="checkbox"/>	3	<input checked="" type="checkbox"/>	4	5	6	7	8
WALKING	1	2	<input checked="" type="checkbox"/>	3	4	5	6	7	8																											
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B. CHECK HOW OFTEN: <table style="width: 100%; margin-top: 5px;"> <tr> <td style="width: 30%;">BENDING</td> <td style="width: 10%;"><input type="checkbox"/> NEVER</td> <td style="width: 10%;"><input type="checkbox"/> OCCASIONALLY</td> <td style="width: 10%;"><input checked="" type="checkbox"/> FREQUENTLY</td> <td style="width: 10%;"><input type="checkbox"/> CONSTANTLY</td> </tr> <tr> <td>REACHING</td> <td><input type="checkbox"/> NEVER</td> <td><input type="checkbox"/> OCCASIONALLY</td> <td><input checked="" type="checkbox"/> FREQUENTLY</td> <td><input type="checkbox"/> CONSTANTLY</td> </tr> </table>					BENDING	<input type="checkbox"/> NEVER	<input type="checkbox"/> OCCASIONALLY	<input checked="" type="checkbox"/> FREQUENTLY	<input type="checkbox"/> CONSTANTLY	REACHING	<input type="checkbox"/> NEVER	<input type="checkbox"/> OCCASIONALLY	<input checked="" type="checkbox"/> FREQUENTLY	<input type="checkbox"/> CONSTANTLY																						
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REACHING	<input type="checkbox"/> NEVER	<input type="checkbox"/> OCCASIONALLY	<input checked="" type="checkbox"/> FREQUENTLY	<input type="checkbox"/> CONSTANTLY																																
C. LIFTING AND CARRYING																																				
THIS EMPLOYEE OCCASIONALLY (UP TO 1/3 OF AN 8-HOUR DAY) LIFTS AND/OR CARRIES: <table style="width: 100%; margin-top: 5px;"> <tr> <td style="width: 30%;"><input type="checkbox"/> LESS THAN 10 LBS.</td> <td style="width: 30%;">Kinds of objects lifted:</td> <td style="width: 40%;"><u>BOOKS/CHARTS</u></td> </tr> <tr> <td><input checked="" type="checkbox"/> 10 LBS.</td> <td>Kinds of objects lifted:</td> <td><u>DESK/CHAIRS</u></td> </tr> <tr> <td><input checked="" type="checkbox"/> 20 LBS.</td> <td>Kinds of objects lifted:</td> <td><u>LEARNING AIDS (OBJECT) I.E. SKELETON</u></td> </tr> <tr> <td><input checked="" type="checkbox"/> 30 LBS.</td> <td>Kinds of objects lifted:</td> <td><u>PROJECTORS</u></td> </tr> <tr> <td><input checked="" type="checkbox"/> 50 LBS.</td> <td>Kinds of objects lifted:</td> <td></td> </tr> <tr> <td><input type="checkbox"/> 50 LBS. OR MORE</td> <td>Kinds of objects lifted:</td> <td></td> </tr> </table>					<input type="checkbox"/> LESS THAN 10 LBS.	Kinds of objects lifted:	<u>BOOKS/CHARTS</u>	<input checked="" type="checkbox"/> 10 LBS.	Kinds of objects lifted:	<u>DESK/CHAIRS</u>	<input checked="" type="checkbox"/> 20 LBS.	Kinds of objects lifted:	<u>LEARNING AIDS (OBJECT) I.E. SKELETON</u>	<input checked="" type="checkbox"/> 30 LBS.	Kinds of objects lifted:	<u>PROJECTORS</u>	<input checked="" type="checkbox"/> 50 LBS.	Kinds of objects lifted:		<input type="checkbox"/> 50 LBS. OR MORE	Kinds of objects lifted:															
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THIS EMPLOYEE FREQUENTLY (1/3 TO 2/3 OF AN 8-HOUR DAY) LIFTS AND/OR CARRIES: <table style="width: 100%; margin-top: 5px;"> <tr> <td style="width: 30%;"><input type="checkbox"/> LESS THAN 10 LBS.</td> <td style="width: 30%;">Kinds of objects lifted:</td> <td style="width: 40%;"><u>BOOKS/CHARTS</u></td> </tr> <tr> <td><input checked="" type="checkbox"/> 10 LBS.</td> <td>Kinds of objects lifted:</td> <td><u>DESK/CHAIRS</u></td> </tr> <tr> <td><input checked="" type="checkbox"/> 20 LBS.</td> <td>Kinds of objects lifted:</td> <td><u>LEARNING AIDS (OBJECT)</u></td> </tr> <tr> <td><input checked="" type="checkbox"/> 30 LBS.</td> <td>Kinds of objects lifted:</td> <td></td> </tr> <tr> <td><input type="checkbox"/> 50 LBS. OR MORE</td> <td>Kinds of objects lifted:</td> <td></td> </tr> </table>					<input type="checkbox"/> LESS THAN 10 LBS.	Kinds of objects lifted:	<u>BOOKS/CHARTS</u>	<input checked="" type="checkbox"/> 10 LBS.	Kinds of objects lifted:	<u>DESK/CHAIRS</u>	<input checked="" type="checkbox"/> 20 LBS.	Kinds of objects lifted:	<u>LEARNING AIDS (OBJECT)</u>	<input checked="" type="checkbox"/> 30 LBS.	Kinds of objects lifted:		<input type="checkbox"/> 50 LBS. OR MORE	Kinds of objects lifted:																		
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<input checked="" type="checkbox"/> 30 LBS.	Kinds of objects lifted:																																			
<input type="checkbox"/> 50 LBS. OR MORE	Kinds of objects lifted:																																			
NAME OF SUPERVISOR (PLEASE PRINT) AUTHORIZED REPRESENTATIVE			TITLE BENEFITS ADMINISTRATOR																																	
PHONE 803-123-4567	DATE 6/15/2006	SIGNATURE		Position Description Attached <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No																																
Return completed form to the SC Retirement Systems (address above). Please call SC Retirement Systems Customer Service with any questions: 1-800-868-9002 (in state) or 803-737-8800																																				

Claims Procedure Act

Claims Procedure Act

Effective July 1, 2003

- **Established under Chapter 21 of Title 9 of the SC Code of Laws.**
- **Designed to create a more efficient and fair procedure for claim disputes.**
- **Must file an appeal within one year of the Retirement Systems' decision.**
- **Prohibits class action lawsuits.**
- **Limits retroactive retirement benefit or monetary relief to one year.**
- **The Budget & Control Board passed a new claims procedure effective July 1, 2005.**
 - **Creates different procedures for appeals of disability denials and appeals of administrative decisions.**

Claims Procedure Act

Administrative Appeal

Administrative Decisions	Disability Retirement Decisions
Claimant makes written appeal to Director of Retirement Systems within one year of administrative decision	Initial review by Disability Determination Provider (DDP) for disability retirement benefits
↓	↓
Claimant is afforded opportunity to present claim in writing to Director for review	
↓	↓
	DDP makes recommendation to Retirement Systems and Retirement Systems approves or denies claim
↓	↓
	If Retirement Systems' denies claim, member may make written appeal to Director of Retirement Systems within 30 calendar days from receipt of decision
↓	↓
	Director forwards claim to Vocational Consultant appointed by the Director for review, conference, and recommendation
↘	↙
Director makes Final Agency Determination	
↓	
Director's decision is final decision of Retirement Systems and State Budget and Control Board	
↓	
Claimant files request for contested case hearing with Administrative Law Court within 30 calendar days after receipt of Retirement Systems' final decision to seek review of Retirement Systems' Final Agency Determination	
↓	
Court of Appeals, and ultimately, South Carolina Supreme Court, may review the Administrative Law Court decision	

Questions?